OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PATIENT DATA

INDIVIDUAL FACILITY TRANSMITTAL FORM

OSHPD Use Only
PM Date: _____
Agent: _____

Facility Name: _____

Facility Identification Number: | | | | | | |

Data Type: ☐ Inpatient ☐ Emergency Department ☐ Ambulatory Surgery

Report Period From: _____ to _____

Total Number of Records: _____

DISKETTE

☐ 3½" Diskette

☐ CD-ROM

Filename:

_____

CERTIFICATION

I, _____, certify under penalty of perjury as follows:
(Name of Individual)

That I am an official of _____ and am duly
(Name of Facility)

authorized to sign this certification; and that, to the extent of my knowledge and information, the accompanying records are true and correct, and that the definitions of the required data elements in Subsection (g) of Section 128735, or Subsection (a) of Section 128736, or Subsection (a) of Section 128737 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this facility.

Dated: _____ By: _____
(Signature)

Facility: _____ Name: _____
(Please Print)

Address: _____ Title: _____

_____ Phone: _____

E-mail: _____